Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: JAMES WEISS, MD 3100 TIMMONS LANE #250 HOUSTON, TX 77027	MFDR Tracking #: M4-10-2917-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN CASUALTY CO OF READING Box #: 47	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a position statement in accordance with rule §133.307.

Amount in Dispute: $305.69

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Initial Position Summary dated March 15, 2010: "**Dispute Facts** This dispute involves treatment provided by James Weiss, MD to injured worker for date of service 12/04/2009. **Carrier's Position** In this matter, the amounts paid by carrier referenced in the provider's MDR Request are inaccurate. Healthcare Provider indicates for the Amount in Dispute:

CPT Code	Amount Billed	Amount in Dispute	Amount HCP indicates Carrier Paid	Amount Carrier actually paid on 12/22/2009
95904	$267.00	$143.27	$123.73	$267.00
95934	$137.42	$137.42	$0.00	$137.42
99070	$25.00	$25.00	$0.00	$25.00

A copy of the EOR referencing these payments was forwarded to the Healthcare provider on 12/22/2009. A copy of which was also attached to the HCP's MDR Request. The Requestor amounts in dispute do not correctly reflect payment submitted to HCP in accordance with the requested billing. As indicated on the EOR, and determined by the Clinical Validation Unit, A Motor Conduction study without f-wave is included in the NCS with F-wave on the same nerve. Same date of service. **Documents Attached** DWC 60 Completed Table with Cover letter & Position Summary EOR dated 12/22/2009. **Request for Relief** Carrier respectfully requests an order of no additional reimbursement due as the amounts in dispute were previously paid in compliance with the Texas Labor Code and the Administrative Rules."

Respondent's Supplemental Position Summary dated March 23, 2010: "Carrier respectfully submits its Supplemental DWC-60 response. These records are being provided pursuant t the rules and should not be used for any other purpose. **Dispute Facts** This dispute involves treatment provided by James Weiss, MD to injured worker for date of service 12/04/2009. **Carrier's Position** Carrier contacted the URA, Coventry, and requested an audit for the disputed date of service in this matter. The URA indicated that: "The bill was processed correctly. As for the clinical validation reduction on code 95904 x 4, CV did deny 95900 x4 because 95900 (motor study without F-wave) would be included in 95903 (motor study with F-wave) when done on the same nerves on the same date of service. It is acceptable to bill with a modifier 59 however use of modifier 59 would indicate multiple nerves were tested, some with and some without Fwaves, describing distinct and independent services on the same day. In this case the modifier 59 would not be appropriate, as the same nerves were tested on the same date of service." **Request for Relief** Carrier respectfully requests an order of no additional reimbursement due as the amounts in dispute were previously paid in compliance with the Texas Labor Code and the Administrative Rules."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
12/4/09	95904	N/A	$143.27	$0.00
12/4/09	95934	N/A	$137.42	$0.00
12/4/09	99070	N/A	$25.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 12/22/2009

   - 150 (900-030) – This charge was reviewed through the clinical validation program
   - W1 (687-004) – According to jurisdiction guidelines, reimbursement is allowed at submitted charges

   Explanation of benefits dated 2/4/2010

   - 18 – Duplicate claim/service
   - 999 – $1,543.03 of the charges are duplicates of bill #88888970-H-716210-0. It has a total allowance of $1,237.34

Issues

1. Was the requestor reimbursed for the disputed CPT codes listed on the DWC-60 Table?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent submitted in their response a copy of the original EOB dated 12/22/2009 showing the disputed codes to be paid at the full billed amount. Therefore, the Division concludes that the services in dispute are paid.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		11/9/10
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.